MIHP Design Workgroup Meeting

August 18, 2005

Present: Paulette Dobynes Dunbar, Sheila Embry, Stacey Duncan-Jackson, Sue Moran, Jackie Prokop, Deb Marciniak, Ingrid Davis, Mary Ludtke, Paul Shaheen, Sandra Brandt, Eileen Guilford, Susan Gough, Judy Fitzgerald, Betty Yancey, Bonnie Ayers, Tom Summerfelt, Dianna Baker, Darlene VanOveren, Health Plan of Michigan, and Rosemary Blashill.

By phone: Ann Bianchi, Anne Young, Patricia Fralick, Belinda Bolton, Carolyn Rowland, Phyllis Meadows, Sr. Barbara Cline, and Janine Chittenden.

Tasks

1. Tom will send Jackie (and the other DWG members) the maternal screener scoring sheet and key for the paper format. (NOTE: It was subsequently determined that the scoring sheet and key weren't ready for distribution.)
2. Jackie will make the following changes to the proposed policy on the new screener:
    a. Include the scoring sheet, scoring key and scoring process. (NOTE: It was subsequently determined that the scoring sheet and key weren't ready for distribution.)
    b. Add a context piece to provide the big picture and signal the evolution of the program.
    c. Add the phrase "in collaboration with the client" to the care plan form and add a short piece to page 2 of the policy narrative addressing this.
3. DCH will post the next draft of the policy on the MIHP web site and notify the DWG by email when it's posted.
4. DCH will send an updated contact list so DWG members can contact state-level people with their input on the next draft.
5. DWG members will comment on the next draft of the proposed policy during the official public comment period.

Update on Status of the Pilot Projects

Sue Moran welcomed the group and introduced Tom Summerfelt, who provided the update on the pilot projects. The plan was that Genesee would use the paper and pencil screener, District 10 would use the PDA, and Kent would use the tablet. However, there have been some tech snafus, as is always the case, so we're not ready to talk about the tech applications of the screener at this point. For the most part, the response to the screener has been overwhelmingly positive – only a few negatives. Initially, Kent providers were concerned about the amount of time it took to do the integrated WIC-MIHP screener. However, once they gained experience with it, the time decreased and they felt they were getting much more accurate, comprehensive information for both WIC and MIHP. The feedback so far is on the paper screener – it will be a while before we get feedback on what it's like for a woman to be asked the questions when the

interviewer is using a tablet or PDA. We should have this by September or October, but we don't expect it to be very different from the feedback on the paper screener.

We started testing the paper screener in March or April. It will be fully implemented by late fall (according to the proposed Medicaid policy we will be discussing later this afternoon). Carolyn said she thought something was going to be added to the screener on cognitive impairment / developmental delays, but she doesn't see it on the version in today's packet.

We don't have any data from women who have had experience with the "old" screening and assessment tools and with the "new" screening and assessment tools. Very few women would have had experience with both.

It was suggested that the new screener is an improvement because it requires much less writing – more of a checklist format. Tom replied that providers are trained in the new format and they say they like it. They feel they are identifying more risks with the screener, especially depression. Because pilots are identifying higher rates of depression with the new screener, we're going to need the infrastructure to respond. There may be a role for paraprofessionals eventually.

It takes about 15 to 20 minutes to do the MIHP screen, and about 20-40 minutes to do the integrated WIC-MIHP version. Kent is now embracing the integrated version – they feel it helps them to identify risks in a more accurate way.

Are the pilots enrolling a greater number of women? Tom said this relates to the case rate and risk stratification. We have 200-250 women in pilots now. Under the old standards, all would qualify for MSS. Tom said he was side-stepping the question, but the new screener is doing exactly what we want it to do – it is distinguishing between women with few risk factors and women with multiple risk factors.

Jackie said that when she drafted the proposed Medicaid policy on the new screener, her understanding was that the stratification piece wasn't ready, so she put an asterisk on certain items / responses on the screener that would make automatically make a woman eligible for the program. Tom said he would run the algorithm. When we get the PDA and tablet formats working, interviewers will be able to enter the data and get back a written report that provides the risk endorsements for the MIHP. We could add a statement that the woman is "in" or "out" and provide a summary. On the WIC side, the interviewer can hit a button that links individual responses to WIC codes.

There's a scoring sheet / key for the paper format, which Tom will send to Jackie. It takes about five minutes to score a screen by hand. The pilots are sending the paper screens to the IHCS and IHCS enters the data into a data base. However, this service won't be available to all providers on Nov. 1 – they'll have to score the screens by hand.

Sue Gough said that private providers don't have tech access, and wonders how feasible tech applications will be, as providers are taking a 4% cut in their reimbursement rate. Tom replied that this is a question DCH will have to figure out. IHCS submitted a HRSA grant application requesting funds to establish an MIHP statewide registry so providers

could enter and retrieve data. Sue Moran said Sue had a valid question and the hope is that there will be positive trade-offs for providers.

IHCS is working on a Spanish version of the screener. The pilots haven't included Spanish-speaking participants as yet, but we will have data on 25 Spanish-speaking participants by the time the pilot phase is completed.

Pat Fralick said her program wants to use the integrated WIC-MIHP screener and asked if it will be available in the tech applications. Tom said yes, but it will take a while to work the bugs out, so it won't be available as of Nov. 1, when the policy on the new screener goes into effect. It will only be available in the pencil-paper format as of Nov. 1.

It's not clear yet if providers like the PDA better than the tablet or vice versa. PDAs give you one question per screen, and tablets give you several questions per screen. You can also use the screener with a regular PC (IHCS is using a PC to enter the data from the pencil-paper screens). The screener was designed for the LCD-PDA, knowing it could also be used with tablets and PCs. The tech applications have been tried, but it will be a while before they're fully piloted.

Stacey said she was at a recent meeting where they were discussing the spread of information, and asked if Tom is computing the time it takes to complete a screen, the amount of time the system is down, provider satisfaction with the process, etc., to assure providers that the tech applications are worth it. Tom said yes, this data is being collected and that we'll have concrete information for the sites when the system goes electronic.

Will the performance measures come from the screener and how will data be collected at the back end? Tom said they're at the point where they are developing the final draft of the infant screener. Then they will develop follow-up screeners that will look similar to the initial screeners to be able to track women over time, see changes, and identify follow-up needs. The details need to be hashed out.

Sue Gough said that the private providers met yesterday and some are in the process of revising their data bases. They need to know what data they will be required to collect for MIHP – they want to be ready to go. Jackie said that DCH is still discussing this internally. Sue said we'll talk about this later on our agenda when we review the handout on key MIHP activities for FY 06 (a very preliminary document which provides some sense of timeframes, but which needs to be fleshed out with DWG input).

Paul asked if there is a mechanism to evaluate the new process in the pilots and in the proposed policy. Tom said there is a mechanism to do this in the pilots, but he's not sure what will be in the policy when the program is fully implemented. Stacey said that the intervention matrix specifies we will collect data on consumer satisfaction, and that specific items on consumer satisfaction are more helpful than global items. She said that this will tie into TQM to help us identify what we need to do to improve the program on an ongoing basis.

Paul said that we want to see that the changes we're making produce better outcomes. Who will establish the relationship with the woman that will result in trust and motivate her to change her behavior? Have you changed anything based on consumer input? Tom said yes (e.g., the sequence of the questions).

Paul said that funders want to see behavior change on the part of the consumer. We need to know the connection between consumer satisfaction with service and outcomes. Stacey said that we will get at this. Data elements will be collected in addition to those in the screener (e.g., does infant intervention reduce days in NICU?). We can use administrative data and pull from several sources. Tom said he is excited about the HRSA grant application for the MIHP registry. Data would be pulled from multiple sources and state-level staff and providers could access the data they need.

Proposed Medicaid Policy Draft on New/Revised MSS/ISS Screening Tool, Assessment Form and Care Plan

Jackie Prokop, MSA, said that yesterday was the end of the initial (internal) comment period on the proposed policy and it is now out in the field for comment. The policy will be issued on Oct. 1 with an effective date of Nov. 1. The version we're looking at today is different from the one that the DWG received by email – this version incorporates the name change from MSS/ISS to Maternal Infant Health Program. Jackie said that in our documents to date, we refer to the new program in 3 different ways: Maternal Infant Health Program; Maternal-Infant Health Program; Maternal and Infant Health Program.

After some discussion, the DWG voted to use the first alternative.

The new screening form needs to be in client charts effective Nov. 1. Jackie noted that an item with an asterisk on the form indicates that a woman is automatically eligible for MIHP if she responds positively to that item, and that we can add or delete asterisks if we need to. If a woman is not eligible for MIHP based on her screening results, but the provider feels the woman still needs the program, the provider can enroll her anyway, as long as the rationale is documented.

Carolyn said that we had planned that all pregnant Medicaid beneficiaries would be eligible, but the new policy does not say this. Jackie replied that this is still our long-term intent, but it won't happen until we move to the case rate reimbursement system. As long as we're still using the fee-for-service reimbursement system, we don't have the ability to tie risk level to payments. As of Nov. 1, we'll be using a new screening tool, but other policy provisions remain the same. We always wanted to screen all Medicaid beneficiaries and the new tool will allow us to screen more women. Implementing the new screener is just an introduction to the new program – we're not implementing a full-blown population-management program at this point. Sue Moran said that allowing providers to be reimbursed for screening is a big first step, because it will help to populate the registry.

Jackie said the policy doesn't speak to low and high risk. Sue Gough said that we're using risk level to determine the intervention, however, so the asterisks will help to

formulate the care plan. The asterisks indicate items that we use for program eligibility now.

Ellen noted that the asterisked items don't correlate with WIC risks. Jackie said that we're developing an integrated WIC-MIHP form. The nutrition questions are on the assessment that is done after the screen is completed.

If all women are eligible, why are we screening? We need to start training people to get used to using the new tools. Tom said that with the current MSS/ISS forms, almost all women are eligible - very few women are turned away. The info from the screening tool and assessment form was not always used in care plan development. Sue noted that the new screening tool is also for data collection purposes to document outcomes.

Paul said that he likes the idea of the gradual transition to the population-based model, but would like to see an agreement/contract with the client to work on identified issues. If she is not willing to make a commitment to work on changing her behavior, she may not get in. How do we educate the client and the provider about this? Jackie said that we could consider adding a box to the end of the care plan where the woman indicates her agreement to make changes, but we aren't at this point yet. Eileen noted that WIC will be moving toward this over the next few years, asking the woman, "Which goals will we be working on today?" The Nurse Family Partnership Program also uses contracts. It was suggested that we wouldn't want to do the screen, and then say, "These are your issues – sign the contract". The worker needs to build a trusting relationship with the woman first.

Pat said this takes us back to a previous discussion on how to partially implement the MIHP. We don't have it all perfectly worked out today and can't implement it anyway because the new payment system isn't developed. We're entering a transition period during which we'll use the new screener and begin to collect data, but the program will be in flux for years. Jackie reiterated that as long as we're still using FFS, we can't enforce many of the new program components we would like to implement.

Tom said that the proposed policy draft doesn't lay out the big-picture vision piece (e.g., population-based model, all women are "in", risk stratification, targeted intervention liked to risk, etc.). Adding this at the front end would help people in the field conceptualize the whole thing, and understand that we will transition to the new program gradually. Jackie said that this information is available on the MIHP web site, but we could also lay it out in a cover letter that would go out with the new policy. Paul said it would be best to include this in the actual policy under intent, to help people put it into context. Jackie will add a context piece to the policy draft to provide the big picture, signaling the evolution of the program.

So, are the asterisks on the screening tool in or out? Sue Moran said they do introduce the idea that certain factors do place a woman at very high risk. Sue Gough said she was getting confused – who's "in" and who's "out" as of Nov. 1, given that the intervention piece is not in place? Are we supposed to serve high-risk women or not? Jackie said that

providers will do what they have always done, including serving high-risk women as best they can in 20 visits.

Stacey noted that at the end of the care plan form, there's no reference to the client. Jackie will add the phrase "in collaboration with the client." She will also add a short piece to page 2 of policy narrative addressing this.

At one point we said that MSS/ISS and MIHP would "run concurrently" for a while. As of January 1, the name will change to MIHP and the two programs will merge into one. Programs can continue to use the old forms with current enrollees, and use the new forms with new enrollees only.

Jackie asked if she should remove the asterisks from the screener or not? Paulette said she should remove them, as they're incomplete in terms of identifying low and high risk. Skilled providers can still evaluate each woman with the screening and assessment tools and use their professional judgment to develop the care plan. The fundamental question that providers must answer is: Does the woman have risks that will affect her pregnancy, impair her health, or impair the infant's health?

The new screening tool covers 11 content areas, allows the interviewer to check off the responses, and has a scoring key to total the risks. A phone participant suggested leaving in the asterisks to make providers more aware of them, and that providers could at least tally the asterisks. Betty reiterated that the asterisks aren't complete. During the public comment period, stakeholders could include their opinions on whether all of the risk factors are important. Jackie will change the policy to include the scoring sheet, scoring key, and scoring process. Tom will send the scoring tool to the DWG. (NOTE: It was subsequently determined that the scoring sheet and key weren't ready for distribution.)

Pat said she can see tallying with the score sheet on paper, but what if we're using an electronic format? Tom said that the scoring process is a lot easier with the tech applications - the computer would print out the whole results summary for you, based upon the risk factor endorsements identified in the screening tool.

Pat commented that the domains on the screening tool don't correlate with same risk factors in the current tool. For example, teen parents are one group we serve now that we couldn't serve using the new tool until the new payment system us in place. Jackie said the policy says that the eligibility criteria (the 8 bullets in the current screening tool) remain the same.

Pat replied yes, but if we start using the new screening tool and matrix, "under 18 years of age" won't have an asterisk. Tom said the new screening tool includes age, educational level, etc. Pat asked if the matrix had changed, then. Tom said those demographics have always been part of the constellation.

If providers use the new screener and identify large numbers of women at high risk, how can we serve them if the new funding mechanism isn't in place? Sue Gough said that private providers are thrilled to be paid for screening, but are afraid of the rush to change payment system. Jackie said women can still get 9 visits.

Right now, providers don't get paid for doing screens, but as of Nov. 1, they will get $20 per screen (which covers a large part of the current assessment tool). The fee for the assessment is being decreased by $10, but providers will end up with a net gain of $10 for doing both the screen and the assessment. Paul said he didn't understand this from the way the draft policy is written, and that this should be explained in print.

Paul asked where is the signal that the MIHP will require much closer partnerships between the MIHP provider and the medical home - the connection is weak now. Ingrid said that MSS providers say that they send info to the physicians, but they don't have time to look at it or respond. Sue Gough said that we establish the bridge but physicians don't always accept it. Jackie said that MSS providers are good about communicating with physicians. Paul said we need to determine how big this problem is and how to address it. Ingrid said it's an issue that needs to be addressed with providers.

Sue Moran said there are lots of issues to address as we transition. She said she hears more comments in favor of including the asterisks on the screener to introduce idea of varying levels of risk and that high-risk women need more intense intervention. She said she also is hearing that although providers will be paid for screening as of November 1, they will continue to use clinical judgment, develop plans, and bill for reimbursement, the same as they have in the past.

Key MIHP Program Development Activities for FY 06

Paulette reviewed the *Key MIHP Program Development Activities for FY 06* document. She explained that this very preliminary draft is a first stab at identifying the key activities that we will undertake in FY 06. Activities are broken down by quarter. The first quarter activities are more specific than the activities in the following quarters at this time. We want to be as clear and specific as possible. Some points that the DWG discussed included the following:

- MDCH will conduct a videoconference on the new prenatal screening tool, modified assessment form, and care plan on October 20 at 6 locations. The notice will go out soon.

- Providers will begin to use the new prenatal screening tool Nov. 1, although they can ask Jackie for additional time start-up time to add items to the tool for local purposes, if needed. All providers will be using the new tool by Jan. 1, 2006.

- Judy noted that *Smoke Free for Baby & Me* doesn't work in tribal communities. Will they be allowed to use a different intervention? If we have evidence that an intervention doesn't work for a particular group, it's certainly valid to propose a different evidence-based intervention.

- We have not gotten to the point of deciding about when we will conduct follow-up screenings during pregnancy - at one point, we had discussed doing this every trimester. We will have to determine appropriate intervals, taking cost-effectiveness into account.

- Will the MIHP Data Reporting Workgroup develop a different discharge summary for data collection purposes? In effect, the infant screener will take the place of the MSS discharge summary, since the MIHP continues after the birth of the infant. There will be interim data collection points as well (e.g., 6-month update).

- Trainings need to be added for the interventions listed at the end of the third quarter.

- Work on the depression and substance abuse interventions will extend beyond FY 06.

- The reimbursement workgroup is at a very preliminary stage at this point. The chair hasn't been appointed, although some folks have begun to look at data. Pat Fralick said that she would like to see local representation on this workgroup.

- Pat also said she thinks that developing online training modules is an excellent idea, and that WIC does this. Paulette noted that this relates to a suggestion Pat made a year ago about making training more available.

- Betty Yancey said it's nice to see we're not sloughing off on transportation and domestic violence.

Sue Moran reiterated that these are just some key concepts right now – we need to add many more activities, provide much more detail, and update the list of activities over time. We need a great deal of input from the DWG on these activities. We will post this draft on the MIHP web site and notify the DWG by email when it's posted. We'll also send an updated contact list so DWG members can contact state-level people with their input.

MIHP Data Reporting / Registry Workgroup Update

Sheila said the Data Reporting / Registry Workgroup met with the Michigan Department of Information Technology (DIT) people to propose the web-based MIHP registry and got DIT's feedback on its ability to create a program for us. It was a positive meeting. DCH already has a program (long-term care screener) that the MIHP registry could mirror. DIT gave us a work plan and price. We surveyed MSS/ISS providers and found they are at various levels with respect to their IT capacity. Rather than roll everything out at once, we will use an incremental process, beginning with the new maternal screener. We need to have a great deal of internal discussion about training, roll-out, bridging of different data systems, etc., and will continue to meet internally. We are not at a point where we have anything specific to share with DWG right now. On page 1 of the proposed policy on the new screener, Jackie talks about previous documents to maintain in the client record and about maintaining the new screener in the record. We will figure out how records will feed into the registry.

Other Questions and Comments

When will the DWG see the draft of the infant screener? Tom said that IHCS has done an internal draft and will release it to the DWG within the next few weeks as an email attachment. Providers will need training on administering the Ages and Stages Questionnaire (ASQ) and on the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE). The intervention matrix won't be issued at the same time – it won't be ready.

Will we have a scoring tool for the infant screener? Tom said IHCS did a final draft on the maternal screener and then spit out the algorithms. The application for the maternal screener will be overlaid on the infant screener, so it shouldn't take too long to develop the scoring tool for the infant screener.

Tom said that for FY 06, the Michigan Families Medicaid Project (currently evaluating the MIHP pilots) will propose conducting pilots to identify the best techniques (traditional vs. adult learning models) for training providers on the different MIHP interventions. The MIHP is about changing behavior in pregnant women but this would be an evaluation of changing behavior in providers.

Homework

We will post this draft on the MIHP web site and notify the DWG by email when it's posted. We'll also send an updated contact list so DWG members can contact state-level people with their input.